FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038877

Facility Name: FOX RIVER PAVILION, LTD.

Address: 400 NEW YORK STREET (Number) AURORA (City) 60505 (Zip Code)

County: KANE

Telephone Number: (630) 897-8714 **Fax #** (630) 897-7123

IDPA ID Number: 36-3890249

Date of Initial License for Current Owners: 6/1/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) MARVIN FOX C.P.A.
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,286	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,286	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,459	1,055	1,826	18,340	8
9	SNF/PED					9
10	ICF	22,799	969		23,768	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,258	2,024	1,826	42,108	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.08%

D. How many bed-hold days during this year were paid by Public Aid?
519 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 1,705

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	159,563	11,817	7,039	178,419		178,419	3,892	182,311			1
2	Food Purchase		181,377		181,377	(17,941)	163,436	(87)	163,349			2
3	Housekeeping	125,917	27,040		152,957		152,957		152,957			3
4	Laundry	66,335	21,647	44	88,026		88,026		88,026			4
5	Heat and Other Utilities			120,638	120,638		120,638	(2,335)	118,303			5
6	Maintenance	55,394		102,300	157,694		157,694	(1,710)	155,984			6
7	Other (specify):*							1,698	1,698			7
8	**TOTAL General Services**	407,209	241,881	230,021	879,111	(17,941)	861,170	1,457	862,627			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,385,126	61,917	222,911	1,669,954		1,669,954	8,689	1,678,643			10
10a	Therapy	16,860	1,593	4,775	23,228		23,228	(590)	22,638			10a
11	Activities	65,181	7,885	1,643	74,709		74,709		74,709			11
12	Social Services	47,413		3,890	51,303		51,303		51,303			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,405	3,405			15
16	**TOTAL Health Care and Programs**	1,514,580	71,395	239,219	1,825,194		1,825,194	11,504	1,836,698			16
	C. General Administration											
17	Administrative	55,121		270,839	325,960		325,960	(181,765)	144,195			17
18	Directors Fees											18
19	Professional Services			53,896	53,896	(600)	53,296	(8,409)	44,887			19
20	Dues, Fees, Subscriptions & Promotions			67,785	67,785		67,785	(22,189)	45,596			20
21	Clerical & General Office Expenses	118,912	48,669	134,704	302,285		302,285	7,484	309,769			21
22	Employee Benefits & Payroll Taxes			341,140	341,140	17,941	359,081		359,081			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,370	2,370		2,370	476	2,846			24
25	Other Admin. Staff Transportation			1,608	1,608		1,608	1,464	3,072			25
26	Insurance-Prop.Liab.Malpractice			71,811	71,811		71,811	58	71,869			26
27	Other (specify):*							24,155	24,155			27
28	**TOTAL General Administration**	174,033	48,669	944,153	1,166,855	17,341	1,184,196	(178,726)	1,005,471			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,095,822	361,945	1,413,393	3,871,160	(600)	3,870,560	(165,764)	3,704,796			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

FOX RIVER PAVILION, LTD.
0038877
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	17,941	
2	FOOD		17,941

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	600	
19	PROFESSIONAL FEES		600

To reclass cost of appealing real estate taxes

Facility Name & ID Number FOX RIVER PAVILION, LTD. #0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			81,853	81,853		81,853	19,559	101,412			30
31	Amortization of Pre-Op. & Org.			26,578	26,578		26,578		26,578			31
32	Interest			291,775	291,775		291,775	4,346	296,121			32
33	Real Estate Taxes			41,538	41,538	600	42,138		42,138			33
34	Rent-Facility & Grounds			213,065	213,065		213,065	9,507	222,572			34
35	Rent-Equipment & Vehicles			12,543	12,543		12,543	1,142	13,685			35
36	Other (specify):*											36
37	**TOTAL Ownership**			667,352	667,352	600	667,952	34,554	702,506			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,236	192,668	281,904		281,904	(27,907)	253,997			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,430	66,430		66,430		66,430			42
43	Other (specify):*	24,694			24,694		24,694	(24,694)				43
44	**TOTAL Special Cost Centers**	24,694	89,236	259,098	373,028		373,028	(52,601)	320,427			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,120,516	451,181	2,339,843	4,911,540		4,911,540	(183,811)	4,727,729			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,980	30		9
10	Interest and Other Investment Income	(145)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(87)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,754)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,479)	21		24
25	Fund Raising, Advertising and Promotional	(13,255)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(11,548)	20		28
29	Other-Attach Schedule	(45,800)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (153,087)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(30,724)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (30,724)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (183,811)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FOX RIVER PAVILION, LTD.

ID# 0038877

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	TRUST FEES	(50)	21	2
3	MARKETING SALARY	(24,694)	43	3
4	CAPITALIZED R&M	(6,419)	6	4
5	ILLINOIS COUNCIL LTC - NON-ALLOW	(168)	20	5
6	NON-ALLOW LEGAL BILLS	(11,037)	19	6
7	CABLE TV	(3,432)	5	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(45,800)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				270		3,622						3,892	1
2	Food Purchase	(87)											(87)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,432)		1,097									(2,335)	5
6	Maintenance	(6,419)		375	4,334								(1,710)	6
7	Other (specify):*				1,698								1,698	7
8	**TOTAL General Services**	(9,938)		1,472	6,302		3,622						1,457	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			21,213			(12,524)						8,689	10
10a	Therapy					(590)							(590)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,405									3,405	15
16	**TOTAL Health Care and Programs**			24,618		(590)	(12,524)						11,504	16
	C. General Administration													
17	Administrative			(181,765)									(181,765)	17
18	Directors Fees													18
19	Professional Services	(11,037)		2,628									(8,409)	19
20	Fees, Subscriptions & Promotions	(24,971)		2,782									(22,189)	20
21	Clerical & General Office Expenses	(84,283)		91,767									7,484	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			476									476	24
25	Other Admin. Staff Transportation			1,464									1,464	25
26	Insurance-Prop.Liab.Malpractice			58									58	26
27	Other (specify):*			24,155									24,155	27
28	**TOTAL General Administration**	(120,291)		(58,435)									(178,726)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(130,229)		(32,345)	6,302	(590)	(8,902)						(165,764)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	1,980		17,579									19,559	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(145)		4,491									4,346	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			9,507									9,507	34
35	Rent-Equipment & Vehicles			1,142									1,142	35
36	Other (specify):*													36
37	**TOTAL Ownership**	1,835		32,719									34,554	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(23,693)	(4,214)						(27,907)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(24,694)											(24,694)	43
44	**TOTAL Special Cost Centers**	(24,694)				(23,693)	(4,214)						(52,601)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(153,087)		374	6,302	(24,283)	(13,116)						(183,811)	45

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRIAN CLOCH	50	SEE ATACHED		SEE ATTACHED		
MICHAEL FILIPPO	50					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,097	$ 1,097	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	375	375	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	21,213	21,213	17
18	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	3,405	3,405	18
19	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	3,836	3,836	19
20	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	15,398	15,398	20
21	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	14,843	14,843	21
22	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	37,224	37,224	22
23	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	4,050	4,050	23
24	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,666	1,666	24
25	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	12,057	12,057	25
26	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	2,628	2,628	26
27	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	2,782	2,782	27
28	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	91,767	91,767	28
29	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	476	476	29
30	V	25	OTHER ADMIN. STAFF TRANS.		QUALITY CARE MANAGEMENT	100.00%	1,464	1,464	30
31	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	58	58	31
32	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	24,155	24,155	32
33	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	17,579	17,579	33
34	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	4,491	4,491	34
35	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	9,507	9,507	35
36	V	35	EQUIPMENT RENTAL		QUALITY CARE MANAGEMENT	100.00%	1,142	1,142	36
37	V								37
38	V	17	CORPORATE ALLOCATION	270,839	QUALITY CARE MANAGEMENT	100.00%		(270,839)	38
39	Total			$ 270,839			$ 271,213	$ * 374	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 2,776	QUALITY CARE MANAGEMENT	100.00%	$ 7,110	$ 4,334	15
16	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%	1,141	1,141	16
17	V								17
18	V	1	DIETICIAN SALARIES	3,203	QUALITY CARE MANAGEMENT	100.00%	3,472	270	18
19	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	557	557	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,979			$ 12,280	$ * 6,302	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 3,488	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	$ 2,898	$ (590)	15
16	V	39	ANCILLARY REHAB	140,195	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	116,502	(23,693)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 143,683			$ 119,400	$ * (24,283)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 6,664	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 2,450	$ (4,214)	15
16	V	10	MEDICAL SUPPLIES	14,076	QUALITY CARE MEDICAL SUPPLY	100.00%	1,552	(12,524)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	3,622	3,622	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 20,740			$ 7,624	$ * (13,116)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRIAN CLOCH	DIR. OF OPERATIC	MANAGEMENT	50.00	SEE ATTACHED	9.2	14.09	ADMIN	$ 37,224	17-7	1
2	MICHAEL FILIPPO	ADMINISTRATIVE	ADMINISTRATIV	50.00	SEE ATTACHED	5.4	12.00	ADMIN	12,057	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 49,281		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	352,747	6	$ 9,193	$	42,108	$ 1,097	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	352,747	6	3,145		42,108	375	2
3	10	SAL-NURSING	PATIENT DAYS	352,747	6	177,703	177,703	42,108	21,213	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	352,747	6	28,527		42,108	3,405	4
5	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	352,747	6	32,137	32,137	42,108	3,836	5
6	17	ADMIN. SAL.- A. SALTZMAN	PATIENT DAYS	352,747	6	128,995	128,995	42,108	15,398	6
7	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	352,747	6	124,342	124,342	42,108	14,843	7
8	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	352,747	6	311,829	311,829	42,108	37,224	8
9	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	352,747	6	33,925	33,925	42,108	4,050	9
10	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	352,747	6	13,958	13,958	42,108	1,666	10
11	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	352,747	6	101,006	101,006	42,108	12,057	11
12	19	PROFESSIONAL FEES	PATIENT DAYS	352,747	6	22,013		42,108	2,628	12
13	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	352,747	6	23,307		42,108	2,782	13
14	21	CLERICAL & GENERAL	PATIENT DAYS	352,747	6	768,752	651,494	42,108	91,767	14
15	24	EDUCATION & SEMINAR	PATIENT DAYS	352,747	6	3,989		42,108	476	15
16	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	352,747	6	12,263		42,108	1,464	16
17	26	INSURANCE	PATIENT DAYS	352,747	6	485		42,108	58	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	352,747	6	202,353		42,108	24,155	18
19	30	DEPRECIATION	PATIENT DAYS	352,747	6	147,266		42,108	17,579	19
20	32	INTEREST	PATIENT DAYS	352,747	6	37,619		42,108	4,491	20
21	34	OFFICE RENT-UNRELATED	PATIENT DAYS	352,747	6	79,644		42,108	9,507	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	352,747	6	9,564		42,108	1,142	22
23										23
24										24
25	TOTALS					$ 2,272,015	$ 1,575,389		$ 271,213	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PAINTING REVENUE	21,912	5	$ 56,124	$ 56,124	2,776	$ 7,110	1
2	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	21,912	5	9,010		2,776	1,141	2
3										3
4	1	DIETICIAN SALARIES	DIETICIAN REVENUE	18,893	6	20,480	20,480	3,203	3,472	4
5	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	18,893	6	$ 3,288	$	3,203	$ 557	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 88,902	$ 76,604		$ 12,280	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Advanced Therapy & Rehab., L.L.C.
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						2,898	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						116,502	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 119,400	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Quality Care Medical Supply
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: ((847)663-1155
Fax Number: ((847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						2,450	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						1,552	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						3,622	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 7,624	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MANUFACTURERS BANK		X	MORTGAGE	$37,104.00	6.15.00	$ 4,200,000	$ 4,180,962	7.01.02	9.5000	$ 221,316	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CORUS BANK		X	WORKING CAPITAL	N/A	4.30.96	900,000		DEMAND	9.5000	33,449	6
7	CHMIT	X		WORKING CAPITAL	N/A		250,000		DEMAND	8.0000	5,475	7
8	MANUFACTURERS BANK		X	LINE OF CREDIT	N/A	6.15.00	900,000	560,000	DEMAND	9.5000	31,534	8
9	TOTAL Facility Related				$37,104.00		$ 6,250,000	$ 4,740,962			$ 291,774	9
	B. Non-Facility Related*											
10	Supplemental Schedule										4,346	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,346	14
15	TOTALS (line 9+line14)						$ 6,250,000	$ 4,740,962			$ 296,120	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
1	INTEREST INCOME						$	$			$ (145)	1
2	ALLOC QUALITY CARE MG										4,491	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 4,346	21

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	41,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	40,538	2
3. Under or (over) accrual (line 2 minus line 1).	$	(462)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	42,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	600	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	42,138	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	42,020	8
	1996	44,205	9
	1997	39,207	10
	1998	39,811	11
	1999	40,538	12

2000 REAL ESTATE TAX ACCRUAL = 40,586 X 1.03 Rounded to 42,000

Diff Real Estate Taxes Paid and Amount used for Accrual Calculation = $48.33 = the adjusted balance from closing.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,808 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 194,020
2. Number of Years Over Which it is Being Amortized: LOAN 12M - MORTG 24M
3. Current Period Amortization: 26,578
4. Dates Incurred: 1993, 1997, 1998, 1999, 2000

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		2000		$ 3,448,500	$ 47,896	39	$ 47,896	$	$ 47,896	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	35,735	555	20	1,788	1,233	12,182	9
10	Various			1994	37,645	1,547	20	1,491	(56)	9,819	10
11	Various			1995	110,619	2,716	20	5,747	3,031	31,067	11
12	THERMO TECH			1996	507	13	20	25	12	125	12
13	H.TIPPINS-LABOR			1996	1,140	29	20	57	28	271	13
14	PC ELECTRIC			1996	2,857	73	20	143	70	691	14
15	H.TIPPINS-LABOR			1996	800	21	20	40	19	193	15
16	CARPETING			1996	2,354	60	20	118	58	570	16
17	BOILER SERVICE			1996	568	15	20	28	13	135	17
18	HANDRAILS			1996	4,552	117	20	228	111	950	18
19	THERMO TECH			1996	3,350	86	20	168	82	826	19
20	MOGILINSKI PAPER HAN			1996	1,500	38	20	75	37	356	20
21	RECEPTION OFFICE			1996	374	10	20	19	9	95	21
22	HABITAT-WALLPAPER			1996	826	21	20	41	20	205	22
23	METAL DOOR			1996	540	14	20	27	13	135	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				49,935	698		1,509	811	2,061	33
34	PAGE 12B TOTALS				107,453	2,672		5,376	2,704	13,952	34
35	PAGE 12A TOTALS				77,124	1,743		3,858	2,115	15,455	35
36	TOTAL (lines 4 thru 35)				$ 3,886,379	$ 58,324		$ 68,634	$ 10,310	$ 136,984	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPETING			1996	636	16	20	32	16	149	9
10	THERMO TECH			1996	831	21	20	42	21	179	10
11	CABINETS			1996	2,543	65	20	127	62	624	11
12	ELEVATOR REPAIRS			1996	1,500	38	20	75	37	306	12
13	CABINETS			1996	2,671	68	20	134	66	625	13
14	WALLPAPER			1996	1,645	42	20	82	40	396	14
15	ALARM & CCTV			1996	3,226	83	20	161	78	671	15
16	WALLPAPER			1996	3,205	82	20	160	78	747	16
17	ALL FLOORS			1996	3,932	101	20	197	96	821	17
18	ALARM SYSTEM			1996	2,831	73	20	142	69	627	18
19	WALLPAPER			1996	640	16	20	32	16	139	19
20	FIRE DOORS			1996	3,593	92	20	180	88	825	20
21	MCL ELECTRICAL			1996	905	23	20	45	22	206	21
22	METAL DOORS			1996	1,968	50	20	98	48	457	22
23	AIR CONDITIONERS			1996	1,132	29	20	57	28	261	23
24	WATER PUMP REPAIR			1996	1,315	34	20	66	32	303	24
25	PAINTING & DEC			1996	6,343		20	317	317	1,453	25
26	ELEVATOR REPAIRS			1996	2,984	77	20	149	72	671	26
27	CABINETS			1996	567	15	20	28	13	119	27
28	HALLWAY CEILING			1997	4,005	103	20	200	97	683	28
29	ROOF			1997	1,334	34	20	67	33	229	29
30	DOOR PANIC DEVICE			1997	3,153	81	20	158	77	540	30
31	CONSTRUCTION			1997	1,337		20	67	67	263	31
32	FIRE DOORS			1997	5,430	139	20	272	133	1,020	32
33	BOILER REPAIR			1997	2,628	67	20	131	64	426	33
34	ENTRANCE DRIVE			1997	15,380	394	20	769	375	2,435	34
35	RANGE FIRE SYSTEM			1997	1,390		20	70	70	280	35
36	TOTAL (lines 4 thru 35)				$ 77,124	$ 1,743		$ 3,858	$ 2,115	$ 15,455	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOOR ALARM			1997	1,910	49	20	96	47	368	9
10	ELEVATOR WORK			1997	5,608	144	20	280	136	887	10
11	CONSTRUCTION			1997		38	20		(38)		11
12	INSTALL FLOOR			1997	1,063	27	20	53	26	181	12
13	DOUBLE DOORS			1997	900	23	20	45	22	176	13
14	CABINETS			1997	1,162	30	20	58	28	227	14
15	CARPET			1997	836	21	20	42	21	165	15
16	FENCE & GATES			1997	2,866	22	20	143	121	424	16
17	FENCE			1997	375	10	20	19	9	68	17
18	CONSTRUCTION			1997	2,492	64	20	125	61	479	18
19	DOOR ALARMS			1998	1,946	50	20	97	47	283	19
20	TANK			1998	8,335	214	20	417	203	904	20
21	EMERG PWR OUTLETS			1998	15,530	398	20	777	379	2,266	21
22	FIRE DAMPERS			1998	3,408	87	20	170	83	482	22
23	DOOR			1998	1,490	38	20	75	37	213	23
24	SEWER PIPE			1998	950	24	20	48	24	140	24
25	HOT WTR HTR			1998	8,900	228	20	445	217	1,075	25
26	FIRE WALLS			1998	1,500	38	20	75	37	156	26
27	GENERATOR REPAIR			1998	12,791	328	20	640	312	1,493	27
28	DOORS			1998	1,551	40	20	78	38	169	28
29	ELECTRICAL WORK			1998	2,000	51	20	100	49	208	29
30	EXIT SIGNS			1998	1,933	50	20	97	47	202	30
31	ELEC PARTS			1998	3,251	83	20	163	80	340	31
32	ACCESS DOORS			1998	1,257	32	20	63	31	152	32
33	RACHELS PLACE IMPROV			1998	5,229	134	20	261	127	544	33
34	FIRE DAMPERS			1998	17,500	449	20	875	426	2,115	34
35	TANK REMOVAL			1999	2,670		20	134	134	235	35
36	TOTAL (lines 4 thru 35)				$ 107,453	$ 2,672		$ 5,376	$ 2,704	$ 13,952	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELEV OP PANEL			1999	2,690	69	20	135	66	191	9
10	ELEV OP PANEL			1999	2,690	69	20	135	66	259	10
11	PUMP/BOILER REPAIR			1999	2,316	59	20	116	57	222	11
12	DOOR			1999	1,696	43	20	85	42	128	12
13	TUCKPOINTING			1999	1,075	28	20	54	26	72	13
14	FIXTURES			1999	603		20	30	30	62	14
15	VARIOUS REPAIRS			1999	1,938		20	97	97	129	15
16	VARIOUS REPAIRS			1999	683		20	34	34	54	16
17	LIGHTING SUPPLIES			1999	1,198		20	60	60	95	17
18	ROOF FANS			1999	2,900	74	20	145	71	218	18
19	CORDED STATION			1999	594		20	30	30	43	19
20	DOORS			2000	1,948	40	20	40		40	20
21	CHILLER COMPRESSOR			2000	19,800	275	20	275		275	21
22	CARPETING			2000	1,407	26	20	26		26	22
23	PUMP REPAIR			2000	1,978	15	20	15		15	23
24	BOILER PUMP			2000	1,166		20	53	53	53	24
25	WALL COVERINGS			2000	722		20	30	30	30	25
26	BLINDS			2000	1,121		20	51	51	51	26
27	FIRE SPRINKLER			2000	576		20	26	26	26	27
28	PAINTING & DECOR			2000	2,834		20	71	71	71	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 49,935	$ 698		$ 1,509	$ 811	$ 2,061	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 243,162	$ 36,566	$ 28,393	$ (8,173)		$ 82,701	37
38	Current Year Purchases	22,723	4,459	4,302	(157)		4,302	38
39	Fully Depreciated Assets	15,310	84	84			15,310	39
40								40
41	TOTALS	$ 281,195	$ 41,109	$ 32,779	$ (8,330)		$ 102,313	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	4,167,574	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	99,433	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	101,413	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	1,980	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	239,297	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

FOX RIVER PAVILION, LTD.
0038877
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
FOX RIVER PAVILION	186,210	19,198	18,874	(324)	65,490
QUALITY CARE	56,952	17,368	9,519	(7,849)	17,211
TOTALS	243,162	36,566	28,393	(8,173)	82,701
LINE 29: CURRENT YEAR					
FOX RIVER PAVILION	21,231	4,247	4,247		4,247
QUALITY CARE	1,492	212	55	(157)	55
TOTALS	22,723	4,459	4,302	(157)	4,302
LINE 30: FULLY DEPRECIATED					
FOX RIVER PAVILION	15,310	84	84		15,310
QUALITY CARE					
TOTALS	15,310	84	84		15,310
TOTALS (Should Tie to Totals on Page 13)					
FOX RIVER PAVILION	222,751	23,529	23,205	(324)	85,047
QUALITY CARE	58,444	17,580	9,574	(8,006)	17,266
TOTALS	281,195	41,109	32,779	(8,330)	102,313

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: BELLEVILLE ASSOCIATES, INC.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		121		$ 213,065			3
4	Additions							4
5			ALLOC QUALITY CARE MGMT		9,507			5
6								6
7	TOTAL		121		$ 222,572 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 01/01/00
    Ending 06/15/00

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 0
13.	/2002	$ 0
14.	/2003	$ 0

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 11,497 Description: COPIER=$7352, ICEMAKER=990,DRINKING WATER=$2013, ALLOC QUALITY CARE=$1142
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	FACILITY	PLYMOUTH VOYAGER	END OF LEASE PAYMENT	2,188	18
19					19
20					20
21	TOTAL		$	$ 2,188	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 2,715	$		$ 2,715	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			442			442	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			179,021			179,021	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				34,390		34,390	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2, 39-3				10,490	54,846		65,336	13
14	TOTAL			$		$ 192,668	$ 89,236		$ 281,904	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	AIR FLUIZED BEDS	21,491
2	TUBE FEEDING	6,664
3	OXYGEN	16,859
4	RESPIRATORY	9,832
5		
6		
7		
8		
9		
10		
		54,846

	Outside Therapies (Column 5 - Other)	Amount
1	RADIOLOGY	7,506
2	LAB SERVICES	2,984
3		
4		
5		
6		
7		
8		
9		
10		
		10,490

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (14,997)	$	1
2	Cash-Patient Deposits	31,550		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	748,412		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,078		6
7	Other Prepaid Expenses	8,138		7
8	Accounts Receivable (owners or related parties)	1,350		8
9	Other(specify): See supplemental schedule	85,374		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 893,905	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	188,300		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,448,500		14
15	Leasehold Improvements, at Historical Cos	358,557		15
16	Equipment, at Historical Cost	232,879		16
17	Accumulated Depreciation (book methods)	(273,229)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	60,941		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	4,001		22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,019,949	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,913,854	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 392,621	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,268		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,780		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,164		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,000		32
33	Accrued Interest Payable	14,577		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 571,410	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	560,000		39
40	Mortgage Payable	4,180,962		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,740,962	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,312,372	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (398,518)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,913,854	$ #REF!	48

*(See instructions.)

Facility Name & ID Number FOX RIVER PAVILION, LTD. **#** 0038877 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
REAL ESTATE TAX ESCROW	22,635	
EMPLOYEE ADVANCES	22,739	
DUE FROM OTHERS	40,000	
	85,374	

OTHER CURRENT LIABILITIES:	Amount	Amount

OTHER NON CURRENT ASSETS:

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (142,986)	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (142,986)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(255,532)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (255,532)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (398,518)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	FOX RIVER PAVILION, LTD.	#	0038877	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(142,986)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(142,986)
Equity(Deficit) from Page 17 Col 1		(398,518)
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		(398,518)

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,637,280	1
2	Discounts and Allowances for all Levels	(492,094)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,145,186	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	344,726	6
7	Oxygen	28,789	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 373,515	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	52,830	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,419	19
20	Radiology and X-Ray	12,563	20
21	Other Medical Services	31,429	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 114,241	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	145	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 145	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	22,921	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,921	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,656,008	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	879,111	31
32	Health Care	1,825,194	32
33	General Administration	1,166,855	33
	B. Capital Expense		
34	Ownership	667,352	34
	C. Ancillary Expense		
35	Special Cost Centers	306,598	35
36	Provider Participation Fee	66,430	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,911,540	40
41	**Income before Income Taxes (line 30 minus line 40)****	(255,532)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (255,532)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **FOX RIVER PAVILION, LTD.** **# 0038877** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	INCOME OVER EXPENSE RELATED TO POTENTIAL SALE	
2	OF FACILITY - NO ADDITIONAL COSTS ON PAGE 3 OR 4	20,578
3	VENDING COMMISSIONS	2,343
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	22,921

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,086	2,348	$ 57,499	$ 24.49	1
2	Assistant Director of Nursing	2,233	2,299	51,791	22.53	2
3	Registered Nurses	30,786	36,538	600,999	16.45	3
4	Licensed Practical Nurses	6,022	6,351	108,411	17.07	4
5	Nurse Aides & Orderlies	53,909	55,806	540,308	9.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,436	1,558	16,860	10.82	8
9	Activity Director	2,746	2,964	33,046	11.15	9
10	Activity Assistants	4,140	4,350	32,135	7.39	10
11	Social Service Workers	5,255	5,455	47,413	8.69	11
12	Dietician					12
13	Food Service Supervisor	2,001	2,251	36,464	16.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,168	19,970	123,100	6.16	15
16	Dishwashers					16
17	Maintenance Workers	4,090	4,384	55,393	12.64	17
18	Housekeepers	17,771	18,579	125,917	6.78	18
19	Laundry	10,753	11,350	66,335	5.84	19
20	Administrator	2,121	2,171	55,121	25.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,341	9,891	118,912	12.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,098	2,098	26,118	12.45	31
32	Other Health Care(specify)					32
33	Other(specify) SEE SUPP	793	797	24,694	30.98	33
34	TOTAL (lines 1 - 33)	176,749	189,160	$ 2,120,516 *	$ 11.21	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	191	$ 7,039	1-3	35
36	Medical Director	80	6,000	9-3	36
37	Medical Records Consultant	72	2,880	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	132	4,584	10-3	39
40	Physical Therapy Consultant	40	1,800	10A-3	40
41	Occupational Therapy Consultant	49	2,225	10A-3	41
42	Respiratory Therapy Consultant	15	750	10A-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	1,643	11-3	44
45	Social Service Consultant	78	3,848	12-3	45
46	Other(specify) LAUNDRY	1	44	4-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	691	$ 30,812		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,574	$ 65,543	10-3	50
51	Licensed Practical Nurses	2,296	86,697	10-3	51
52	Nurse Aides	3,422	61,115	10-3	52
53	TOTAL (lines 50 - 52)	7,292	$ 213,355		53

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MARKETING	793	797	24,694	$ 30.98
	793	797	$ 24,694	$ 30.98

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
KEN BOGARD	ADMINISTRATOR	0	55,121
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,121

B. Administrative - Other

Description	Amount
QUALITY CARE MANAGEMENT	$ 270,839
TOTAL (agree to Schedule V, line 17, col. 3)	$ 270,839
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HOLLEB & COFF	LEGAL	$ 3,208
METZLER, PURTILL & STELLE	LEGAL	5,008
WALINSKI & TRUNKETT	LEGAL	133
SACHNOFF & WEAVER	LEGAL	10,964
WINSTON & STRAWN	LEGAL	6,212
ZIMMERMAN REAL ESTATE	APPRAISAL	600
HANSEN ASSOCIATES	ARCHITECTS	1,522
HDSI & RMS	COMPUTER CONSULTANT	5,979
HORIZON HEALTHCARE	COMPUTER CONSULTANT	2,100
PERSONNEL PLANNERS	UNEMPLOYMENT CNSLT	698
COMMITMENT CONSULTING	ACCT. REC. CONSULTANT	1,404
FR&R	ACCOUNTING	16,068
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 53,896

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,270
Unemployment Compensation Insurance	24,029
FICA Taxes	157,679
Employee Health Insurance	108,559
Employee Meals	17,941
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSE	6,494
EMPLOYEE BENEFITS	12,986
HOLIDAY EXPENSES	123
TOTAL (agree to Schedule V, line 22, col.8)	$ 359,081

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	35,220
Health Care Worker Background Check	720
(Indicate # of checks performed 60)	
YELLOW PAGE ADVERTISING	11,548
PROMOTIONAL ADVERTISING	13,255
DUES & SUBSCRIPTIONS	980
IL COUNCIL LTC	4,429
LICENSES & FEES	1,465
ALLOC QUALITY CARE MGMT	2,783
Less: Public Relations Expense	( )
Non-allowable advertising	(13,255)
Yellow page advertising	(11,548)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,597

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,370
ALLOC QUALITY CARE MGMT	476
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,846

**See instructions.

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FOX RIVER PAVILION, LTD. # 0038877 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LTC =$4,429**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **579** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **66,429**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **17,941** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw